

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1327

62-003633

STATE FILE NUMBER

AMENDED

Registration District No.

FILED FEB 7 1962

Primary Registration District No.

Registrar's No.

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>Okawville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>Okawville</u>	
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>W.</u> Last <u>CRALLEY</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Minister</u>	
11. BIRTHPLACE (City and state or country) <u>Carmi, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>John Cralley</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>Helen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Lawrence Cralley Jr., Okawville, Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIO-PULMONARY AMYLOIDOSIS</u> DUE TO (c) <u>289.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>LESS THAN 1 HOUR</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PARA-ESOPHAGEAL HERNIA AND ESOPHAGITIS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>12:40</u> a.m. <u>12:40</u> p.m. Month, Day, Year <u>JULY 2, 1926</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Okawville, Ill.</u>	
21. I attended the deceased from <u>JULY 2, 1926</u> to <u>JAN. 29, 1962</u> and last saw her alive on <u>JAN. 29, 1962</u> Death occurred at <u>12:40 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title) 22b. ADDRESS <u>BARNES HOSPITAL</u> 22c. DATE SIGNED <u>1/30/62</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) <u>Okawville, Ill.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 1700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 30 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3653

P. O. Address St. Louis, Mo

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.